SERFF Tracking #: ACEH-130802461 State Tracking #:

Company Tracking #: 16-AH-2013652

State: District of Columbia Filing Company: Combined Insurance Company of America

TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness

**Product Name:** 146500R-DC - Critical Illness **Project Name/Number:** 16-AH-2013652/16-AH-2013652

# Filing at a Glance

Company: Combined Insurance Company of America

Product Name: 146500R-DC - Critical Illness

State: District of Columbia

TOI: H07I Individual Health - Specified Disease - Limited Benefit

Sub-TOI: H07I.001 Critical Illness

Filing Type: Form

Date Submitted: 11/10/2016

SERFF Tr Num: ACEH-130802461

SERFF Status: Assigned

State Tr Num:

State Status:

Co Tr Num: 16-AH-2013652

Implementation On Approval

Date Requested:

Author(s): Deborah Shortridge, Marivic Chiong
Reviewer(s): Colin Johnson (primary), Andre Beard

Disposition Date:
Disposition Status:
Implementation Date:

State: District of Columbia Filing Company: Combined Insurance Company of America

TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness

**Product Name:** 146500R-DC - Critical Illness **Project Name/Number:** 16-AH-2013652/16-AH-2013652

# **General Information**

Project Name: 16-AH-2013652 Status of Filing in Domicile: Pending

Project Number: 16-AH-2013652 Date Approved in Domicile:

Requested Filing Mode: Review & Approval Domicile Status Comments: Similar forms were filed with our

domicile state, Illinois, on September 9, 2016.

Explanation for Combination/Other: Market Type: Individual Submission Type: New Submission Individual Market Type:

Filing Status Changed: 11/10/2016

State Status Changed:

Deemer Date: Created By: Deborah Shortridge

Submitted By: Deborah Shortridge Corresponding Filing Tracking Number:

Filing Description:

Overall Rate Impact:

Combined Insurance Company of America

FEIN Number: 36-2136262 NAIC Number: 626-62146

Form No. 146500R-DC - Critical Illness Application Form No. 146700R-DC - Cancer Only Application

Individual A&H

FILING SUBMITTED FOR REVIEW & APPROVAL

This is a new filing. Form Nos. 146500R-DC and 146700R-DC was previously approved under SERFF Tracking Number ACEH-130764879 on October 28, 2016. These forms are identical to the previously approved forms except that we have removed the sentence "If coverage applied for includes Sickness Rider, please complete the attestation below (If the Proposed Insured checks "No", the Sickness Rider will not be issued)." Redlines copies of the forms are attached for your information.

These forms have not been implemented and will replace our prior filing that was approved under SERFF Tracking Number ACEH-130764879 on October 28, 2016.

Application Form No. 146500R-DC will be used with Critical Illness Policy, Form No. 16660-DC and its associated forms which were approved on November 16, 2015 under SERFF Tracking No.ACEH-130010408. Application Form No. 146700R-DC will be used with the Cancer Only Policy, Form No. 16738-DC and its associated forms which were approved on November 16, 2015 under SERFF Tracking No.ACEH-130010408.

The Conditional Receipt that will be used with Application Form Nos. 146500R-DC and 146700R-DC is Form No. 164035R-1H, has been approved on January 15, 2015, under SERFF Tracking No.ACEH-129882918.

The application forms will be completed and/or transmitted either by paper or through electronic means. We certify that we will comply with your state's statutes regarding privacy and electronic signatures.

A Variability Memorandum for each application form explaining the bracketed items are included for your reference.

The forms are in final printed format. However, it is possible that actual issued forms may have different format and font style (but not the type size) as a result of different computer publishing systems. Therefore, page breaks may occur at different lines. We do not anticipate refiling for typographical errors, format changes or font style variations.

State: District of Columbia Filing Company: Combined Insurance Company of America

TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness

**Product Name:** 146500R-DC - Critical Illness **Project Name/Number:** 16-AH-2013652/16-AH-2013652

We appreciate your time in reviewing this filing. Please feel free to call me at our toll free number or email me if you have further questions or need additional information.

# **Company and Contact**

## **Filing Contact Information**

Deborah Shortridge, Senior Policy Analyst deborah.shortridge@combined.com

1000 Milwaukee Ave 847-953-1534 [Phone] Glenview, IL 60025 847-953-1557 [FAX]

**Filing Company Information** 

Combined Insurance Company of CoCode: 62146 State of Domicile: Illinois

America Group Code: 626 Company Type: A&H 1000 North Milwaukee Ave. Group Name: Chubb State ID Number:

Glenview, IL 60025 FEIN Number: 36-2136262

(847) 953-2025 ext. [Phone]

# **Filing Fees**

Fee Required? No Retaliatory? No

Fee Explanation:

State: District of Columbia Filing Company: Combined Insurance Company of America

TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness

Product Name:146500R-DC - Critical IllnessProject Name/Number:16-AH-2013652/16-AH-2013652

# Form Schedule

Lead	Form Number: 16	-AH-2013652						
Item	Schedule Item	Form	Form	Form	Form	Action Specific	Readability	
No.	Status	Name	Number	Type	Action	Data	Score	Attachments
1		Critical Illness Application	146500R- DC	AEF	Initial		50.850	146500R-DC.pdf
2		Cancer Only Application	146700R- DC	AEF	Initial		51.930	146700R-DC.pdf

Form Type Legend:

J	po =090a.		
ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
ОТН	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

# COMBINED INSURANCE COMPANY OF AMERICA

**Application for Critical Illness Coverage** 

Home Office: [Chicago, Illinois]
[LANGUAGE PREFERENCE [□ E] [□ S] [□ F]]

I am applying for this covera	age based on the following info	ormation:	(Home Office U	se)	
[ACTION REQUESTED:	[ □ New Policy] [	☐ Policy Chang	e] [□R	Reinstatement]]	
Proposed Insured's Name (First MI Last)			e	Birthdate: MM/DD/YYYY	Age
Proposed Insured's Home A	ddress (Street)	City		State	Zip
[Landline Phone Number]	[Mobile Phone Number]	[Email]		1	
Employer Name	1	[Work Ph	one Number]		
Employer Address (Street)		City		State	Zip
Beneficiary's Full Name			Relationship		
Beneficiary's Address (Stree	et)	City	City		Zip
Billing Address if different than residence (Street)				State	Zip
Will this policy replace any ex	isting policies for the Proposed	Insured?	□ Yes □ N	0	
	nold income [\$15,000] per year or me ed is not eligible for coverage.		□ Yes □ No]		
In the past [12 months], has the Proposed Insured smoked cigarettes,				Height	Weight
C-CICALEUES, CICALS, DIDE OF USECT	□ Yes □ No			100	

[Bar Code] [Application Number] [5 9 0 2]

COVERAGE TYPE  FACE AMOUNT (up to \$50,000)  PAYMENT METHOD  PREMIUM AMOUNT  [									
profession, or taken any prescription medicine for:  a. Heart fallure, angina, stoke, transient slower peak to repair carried.  b. Lung fallure, Chronic Obstructive LungPulmonary disease or Emphyseman?  c. Organ transplant, liver, kidney or pancreatic fallure, cirhosis of the liver, or hepatitis B or C?  d. Cancer (except basel cell or squamous cell cardionma), melanoma, Hodgkins disease, leukemia or malignant growth?  e. Insulin-dependent diabete sid any age or non-insulin dependent diabete diagnosed under age 40?  f. Bipolar disorder, schizophrenia, psychosis, alcoholism or drug addiction? g. Dementia, Alzheimer's disease, Parkinsoris disease on Whitliple Scelerosis?  2. Within the past [10 years], has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for human immunodeficiency virus (AIDS virus) or acquired immunodeficiency syndrome (AIDS)?  3. Within the past [10 years], has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for human immunodeficiency virus (AIDS virus) or acquired immunodeficiency syndrome (AIDS)?  3. Within the past [10 years], has the Proposed Insured been convicted of reckless driving or driving under the influence of alcohol or lilegal drugs, been on parole, incarcerated or convicted of a felony?  4. Within the past [6 months] has the Proposed Insured baem diagnosic tests or procedures for which the results are not yet known, or has the Proposed Insured baem diagnosic tests and procedures for which the results are not yet known, or has the Proposed Insured baem diagnosic tests and procedures for which the results are not yet known, or has the Proposed Insured baem diagnosic tests and procedures for which the results are not yet known, or has the Proposed Insured baem diagnosic tests and procedures for which the results are not yet known, or has the Proposed Insured baem diagnosic tests and procedures that have not yet when yet and	I represent that the answers	to the below que							
a. Heart failure, angina, stroke, transient ischemic attack, heart attack, chronic artial fibrillation, coronary artery disease that required angioplasty or stent placement, heart valve repaird or replacement?  b. Lung failure, Chronic Obstructive Lung/Pulmonary disease or Emphysema?  c. Organ transplant, liver, kidney or pancreatic failure, cinthosis of the liver, or hepatitis B or C?  d. Cancer (except basal coll or squamous cell carcinoma), melanoma, Hodgkins disease, leukemia or malignant growth?  e. Insulin-dependent diabetes at any age or non-insulin dependent diabetes diagnosed under age 40?  g. Dementia, Alzheimer's disease, Parkinson's disease or Multiple Sclerosis?  2. Within the past [10 years], has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for human immunodeficiency vinus (AIDS virus) or acquired immunodeficiency syndrome (AIDS)?  3. Within the past [10 years], has the Proposed Insured been convicted of reckless driving or driving under the influence of alcohol or illegal drugs, been on parole, incarcerated or convicted of a fection?  4. Within the past [6 months] has the Proposed Insured had any diagnostic tests on procedures for which the results are not yet known, or has the Proposed Insured and any diagnostic tests and procedures that have not yet been performed?  5. [Within the past [6 months] has the Proposed Insured submitted an application for [life.] [or] [critical illness] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]  If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.  WINDERWRITING INFORMATION  Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology  frees place and the proposed function of the proposed function of the proposed functio				ed any med	ical advice or treatment	from a member of the medic	al		
required angioplasty or stent placement, heart valve repair or replacement?  b. Lung failure, Chronico Ostrudev Lung/Priomonary disease or Emphysema?  c. Organ transplant, liver, kidney or pancreatic failure, cirrhosis of the liver, or hepatitis Bor C?  d. Cancer (except basal cell or squamous cell cardiormal), melanoma, Hodgkins disease, leukemia or malignant growth?  e. Insulin-dependent diablest air any age or non-insulin dependent diablest air diagnosed under age 40?  f. Bipolar disorder, schizophrenia, psychosis, alcoholism or drug addiction? g. Dementia, Alzheimer's disease, Parkinsoris disease or Multiple Scelerosis?  2. Within the past [10 years], has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for human immunodeficency syndromic (AIDS)?  3. Within the past [10 years], has the Proposed Insured been convicted of reckless driving or driving under the influence of alcohol or illegal drugs, been on parole, incarcerated or convicted of a feloncy?  4. Within the past [6 months] has the Proposed Insured been availy diagnostic tests or procedures for which the results are not yet known, or has the Proposed Insured been availy diagnostic tests and procedures for which the results are not yet known, or has the Proposed Insured band an application for [life], or [or life] allienses] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]  If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.  UNDERWRITING INFORMATION  Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology report, echocardiogram, or from imaging, CT or MRI scan?  If "Yes"; please provide details below:  Medical/Diagnostic Diagnostic Diagnostic Statism and the proposed insured been diagnosed with a medical cond				heart attac	k chronic atrial fibrillatio	n coronany arteny disease tha	<b>1</b>	Y	es No
b. Lunig failure, Chronice Obstructive Lung/Pulmonary disease or Emphyserma?  c. Organ transplant, liver, kidney or pancreatic failure, circhosis of the liver, or hepatitis B or C?  d. Cancer (except basal cell or squamous cell carcinoma), melanoma, Hodgkin's disease, leukemia or malignant growth?  e. Insulin-dependent diabetes at any age or non-insulin dependent diabetes diagnosed under age 40?  f. Bipolar disorder, schizophrenia, psychosis, alcoholism or drug addiction?  g. Dementia, Alzheimer's disease, Parkinson's disease or Multiple Sclerosis?  2. Within the past [10 years], has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for human immunodeficiency virus (AIDS virus) or acquired immunodeficiency syndrome (AIDS)?  3. Within the past [10 years], has the Proposed Insured been convicted of reckless driving or driving under the influence of alcohol or illegal drugs, been on pariote, incarcerated or convicted of a feliony?  4. Within the past [6 months] has the Proposed Insured been convicted of reckless driving or driving under the influence of alcohol or illegal drugs, been on pariote been recommended to have diagnostic tests and procedures for which the results are not yet known, or has the Proposed Insured submitted an application for [file.] [or] [critical illness] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]  If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.  UNDERWRITING INFORMATION  Within the past [2 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology  Yes No report, echocardiogram, or from imaging, CT or MRI scan?  If "Yes", please provide details below:  Medical/Diagnostic Diagnostic Diagnosis Treatment Dates Physician Name/ Address/Phone No.    Bi-weekly EFT]   D	•					ii, coronary artery disease trie	ıı		] 🗆
d. Cancer (except basal cell or squamous cell carcinoma), melanoma, Hodgkin's disease, leukemia or malignant growth?  e. Insulin-dependent diabetes at any age or non-insulin dependent diabetes diagnosed under age 40?  f. Bipolar disorder, schizophrenia, psychosis, alcoholism or drug addiction?  g. Dementia, Alzheimer's disease, Parkinson's disease or Multiple Sclerosis?  2. Within the past [10 years], has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for human immunodeficiency virus (AIDS virus) or acquired immunodeficiency syndrome (AIDS)?  3. Within the past [10 years], has the Proposed Insured been convicted of reckless driving or driving under the influence of alcohol or illegal drugs, been on parole incarcerated or convicted of a felony?  4. Within the past [6 months] has the Proposed Insured bad any diagnostic tests and procedures for which the results are not yet known, or has the Proposed Insured bad any diagnostic tests and procedures that have not yet been performed?  5. [Within the past [6 months] has the Proposed Insured submitted an application for [life.] [or] [critical iliness] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]  If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.  UNDERWRITING INFORMATION  Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnositic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology  Yes No report, echocardiogram, or from imaging, CT or MRI scan?  If "Yes", please provide details below:  Medical/Diagnostic  Diagnosis  Treatment  Dates  Physician Name/ Address/Phone No.    Bi-weekly EFT]   Monthly Credit Card    Quarterly Credit Card    Quarterly Credit Card    Quarterly Credit Card								_	_
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Numan immunodeficiency virus (AIDS virus) or acquired immunodeficiency syndrome (AIDS)?  3. Within the past [10 years], has the Proposed Insured been convicted of reckless driving or driving under the influence of alcohol or illegal drugs, been on parole, incarcerated or convicted of a felony?  4. Within the past [6 months] has the Proposed Insured had any diagnostic tests or procedures for which the results are not yet known, or has the Proposed Insured submitted an application for [file] [or] [orlical illness] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]  If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.  WINDERWRITING INFORMATION  Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology  Yes No report, echocardiogram, or from imaging, CT or MRI scan?  If "Yes", please provide details below:  Medical/Diagnostic Diagnosis Treatment Dates Physician Name/ Address/Phone No.  PLAN SELECTION  COVERAGE TYPE FACE AMOUNT (up to \$50,000) PREMIUM AMOUNT  [I] Choice] [XXXXX] [XXX] [WXX] [WXX] [WXXX] [WXXXX] [WXXX] [WXXX] [WXXXX] [WXXXXX] [WXXXXX] [WXXXXXX [WXXXX] [WXXXXX [WXXXX] [WXXXX] [WXXXX [WXXXX] [WXXXX [WXXXX] [WXXXX [WXXXX] [WXXXX [WXXXX [WXX	·						L		
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4. Within the past [6 months] has the Proposed Insured had any diagnostic tests or procedures for which the results are not yet known, or has the Proposed Insured been recommended to have diagnostic tests and procedures that have not yet been performed?  [5. [Within the past [6 months] has the Proposed Insured submitted an application for [life,] [or] [pricinal illness] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]  If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.  UNDERWRITING INFORMATION  Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology  Yes No report, echocardiogram, or from imaging, CT or MRI scan?  If "Yes", please provide details below:  Medical/Diagnostic Diagnosis Treatment Dates Physician Name/Address/Phone No.  PAYMENT METHOD PREMIUM Address/Phone No.  PREMIUM ADDITIONAL COVERAGE TYPE FACE AMOUNT (up to \$50,000) PAYMENT METHOD PREMIUM AMOUNT  [Choice] [XXXXX] [XXX] [XXX] [Choice] [Choice] [Choice] [XXXXXX] [XXX] [Choice] [							nol or		
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5. [Within the past [6 months] has the Proposed Insured submitted an application for [life,] [or] [critical illness] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]  If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.  UNDERWRITING INFORMATION  Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology Yes No report, echocardiogram, or from imaging, CT or MRI scan?  If "Yes"; please provide details below:  Medical/Diagnostic Diagnosis Treatment Dates Physician Name/ Address/Phone No.  PREMIUM Address/Phone No.  FACE AMOUNT (up to \$50,000) PAYMENT METHOD PREMIUM AMOUNT  [Choice] [XXXXX] [XXX] [Choice] [XXXXX] [XXX] [Choice] [Counterly Credit Card] [Counterly EFT] [Counterly Credit Card] [Counterly Credit Card] [Counterly EFT] [Counterly EFT] [Counterly Credit Card] [Counterly EFT] [Counterly EFT] [Counterly Credit Card] [Counterly EFT] [Counterl								-	, n
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### If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.  ### INDERWRITING INFORMATION    Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology report, echocardiogram, or from imaging, CT or MRI scan?    Medical/Diagnostic							iy inlourur		
UNDERWRITING INFORMATION  Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology report, echocardiogram, or from imaging, CT or MRI scan?  If "Yes", please provide details below:  Medical/Diagnostic Diagnosis Treatment Dates Physician Name/ Address/Phone No.  PLAN SELECTION  COVERAGE TYPE FACE AMOUNT (up to \$50,000) PAYMENT METHOD PREMIUM AMOUNT  [ Choice] [XXXXX] [XXX] [CPreferred] [XXXXX] [XXX] [CPreferred] [XXXXX] [XXX] [CPREFIT] [CPR				·					
Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology report, echocardiogram, or from imaging, CT or MRI scan?  If "Yes", please provide details below:  Medical/Diagnostic Diagnosis Treatment Dates Physician Name/Address/Phone No.  PLAN SELECTION  COVERAGE TYPE FACE AMOUNT (up to \$50,000) PAYMENT METHOD AMOUNT  [ Choice] [XXXXX] [XXX] [XXX] [C   Quarterly EFT] [ Monthly Credit Card] [ Monthly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [ Quarterly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [ Quarterly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [ Quarterly EFT] [ Quarterly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [ Quarterly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [	If any of the above ques	stions are answe	ered "Yes", t	he Propos	sed Insured is not eli	gible for coverage.			
Medical/Diagnostic Diagnosis Treatment Dates Physician Name/ Address/Phone No.  PLAN SELECTION  COVERAGE TYPE  FACE AMOUNT (up to \$50,000)  [Choice] [XXXXX] [XXX] [CD Preferred] [XXXXX] [XXX] [CD Quarterly EFT] [CD Quarterly EFT] [CD Quarterly Credit Card] [CD Quarterly Credit Card] [CD Quarterly EFT] [CD Quarterly Credit Card] [CD Quarterly Credit Card] [CD Quarterly EFT] [CD Quarterly Credit Card] [CD Quarterly Credit Ca	medical or diagnostic tests	, including but I	not limited to	, laborato					
Address/Phone No.   Address/Phone No.   Address/Phone No.     Address/Phone No.     Address/Phone No.     Address/Phone No.     PAYMENT METHOD   PREMIUM AMOUNT     Choice   [XXXXX] [XXX]	If "Yes", please provide d	etails below:							_
COVERAGE TYPE  FACE AMOUNT (up to \$50,000)  PREMIUM AMOUNT  [ Choice] [XXXXX] [XXX] [ Preferred] [XXXXX] [XXX]  \$  [ Quarterly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [ Semi-Annual Credit Card]  [ Quarterly EFT]	_	Diagno	osis		Treatment	Dates			
COVERAGE TYPE  FACE AMOUNT (up to \$50,000)  PREMIUM AMOUNT  [ Choice] [XXXXX] [XXX] [ Preferred] [XXXXX] [XXX]  \$  [ Quarterly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [ Semi-Annual Credit Card]  [ Quarterly EFT]									
COVERAGE TYPE  FACE AMOUNT (up to \$50,000)  PREMIUM AMOUNT  [ Choice] [XXXXX] [XXX] [ Preferred] [XXXXX] [XXX]  \$  [ Quarterly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [ Semi-Annual Credit Card]  [ Quarterly EFT]									
COVERAGE TYPE  FACE AMOUNT (up to \$50,000)  PREMIUM AMOUNT  [ Choice] [XXXXX] [XXX] [ Preferred] [XXXXX] [XXX]  \$  [ Quarterly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [ Semi-Annual Credit Card]  [ Quarterly EFT]									
COVERAGE TYPE  FACE AMOUNT (up to \$50,000)  PREMIUM AMOUNT  [ Choice] [XXXXX] [XXX] [ Preferred] [XXXXX] [XXX]  \$  [ Quarterly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [ Semi-Annual Credit Card]  [ Quarterly EFT]									
COVERAGE TYPE  FACE AMOUNT (up to \$50,000)  PREMIUM AMOUNT  [ Choice] [XXXXX] [XXX] [ Preferred] [XXXXX] [XXX]  \$  [ Quarterly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [ Semi-Annual Credit Card]  [ Quarterly EFT]									
(up to \$50,000)  [ Choice] [XXXXX] [XXX] [XXX] [ Preferred] [XXXXX] [XXX] [XXX]  \$ [ Monthly EFT] [ Quarterly Credit Card] [ Quarterly Credit Card] [ Quarterly EFT]	PLAN SELECTION								<del>_</del>
[□ Choice] [XXXXX] [XXX] [XXX] [D Preferred] [XXXXX] [XXX] [D Quarterly EFT] [□ Monthly EFT] [□ Quarterly Credit Card] [□ Quarterly EFT] [□ Semi-Annual Credit Card]	I TIVEDAGE I VDE			PAY	YMENT METHOD				
[ Choice] [XXXX] [XXX] [XXX] [XXX] [Choice] [ Monthly EFT] [ Quarterly Credit Card] [ Quarterly EFT] [ Semi-Annual Credit Card]	(up to \$50,000)		),000)			_	АМО	UNI	
[□ Annual Bill] [□ Other]				[□ Monthly EFT]       [□ Quarterly Credit Card]         [□ Quarterly EFT]       [□ Semi-Annual Credit Card]         [□ Semi-Annual EFT]       [□ List Bill]		\$			

[Bar Code] [Application Number] [5 9 0 3]

# DECLARATIONS – This section must be read, signed, and dated by Proposed Insured.

## PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance approves my application, the contract is issued, and the required premium is received by Combined Insurance. In applying for this coverage, I represent and affirm the following:

- 1. The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.
- [2. I received the [Outline of Coverage,] [Privacy Notice][,][and][the MIB Pre-Notice][,][and the Notice Regarding The Fair Credit Reporting Act].]

### CONFIDENTIALITY OF MEDICAL INFORMATION

The medical information disclosed on this Application will not be disclosed to any person without the authorization of the Proposed Insured.

For purposes of this application, "Date of Application" is the date the Licensed Agent/Producer receives and signs the application.

[This application may be completed by electronic or telephonic means. I acknowledge that Combined Insurance or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. If completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. If completed by telephonic means, I acknowledge that I have not myself physically signed the application, but instead I hereby authorize Combined Insurance or its agent to accept my voice signature response. The responses received on this application will be attached and made part of the Policy.]

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

**NOTICE:** This policy may only be issued if you have minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or you are treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). If you have employer-sponsored coverage, COBRA coverage, insurance purchased from DC Health Link, or other similar insurance, you likely have minimum essential coverage. If your minimum essential coverage is terminated for any reason, you should notify the company immediately.

(1) Do you have comprehensive medical coverage including the minimum essential coverage required by	
the Affordable Care Act (ACA) or are you treated as having minimum essential coverage due to your status	
as a bona fide resident of any possession of the United States?	☐ Yes ☐ No
If you answered No to question 1, you are not eligible for this policy, in the form of hospital or fixed indemnity insu	ırance.
(2) Do you understand most supplemental policies may not pay full benefits if your ACA compliant	
minimum essential coverage plan is not in force?	☐ Yes ☐ No
(3) Do you understand that the benefits provided under this policy may be limited?	☐ Yes ☐ No

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.					
[ By checking this box, I [PROPOSE insurance. I represent and affirm that the inform my knowledge and belief, and that I have review state.]	nation I have provided on	this application is accura	te and complete to the best of		
XSignature of Proposed Insured	City	State	Date		
I, the authorized agent/producer, have on the Dat Insured, or have sent this application to the Propos					
X Signature of Licensed Agent/Producer	Agent Code	Date	e of Application		

[6 1 0 1] [Application Number]

# COMBINED INSURANCE COMPANY OF AMERICA

-					Home Office: [Chio	cago, Illinois] NCE [□ E] [□ S] [□ F]]
	ge based on the following infor	mation:	(Home Office Us	se)		
[ACTION REQUESTED:	<b>[</b> □ New Policy ] [□	Policy Change	e] [ $\square$	☐ Reinstatemer	nt]]	
Proposed Insured's Name (F	ïrst MI Last)	☐ Male ☐ Femal	le	Birthdate:	MM/DD/YYYY	Age
Proposed Insured's Home Ad	ddress (Street)	City			State	Zip
[Landline Phone Number]	[Landline Phone Number] [Mobile Phone Number]					
Employer Name		[Work Pho	one Number]			
Employer Address (Street)		City			State	Zip
Beneficiary's Full Name					Relationship	
Beneficiary's Address (Street	t)	City			State	Zip
Billing Address if different tha	an residence (Street)	City	City State		State	Zip
Will this policy replace any exis	sting policies for the Proposed Ins	sured?	□ Yes □ No	0		
	old income [\$15,000] per year or mor dis not eligible for coverage.]	·e?	□ Yes □ No]			
· -	roposed Insured smoked cigarettes,				Height	Weight
e-cigarettes, cigars, pipe or used ni	cotine or tobacco products?	l Yes □ No	1		FTIN.	LBS.
QUALIFICATION QUESTIONS:  I represent that the answers to the below questions are accurate and complete to the best of my knowledge and belief.  1. Within the past [10 years], has the Proposed Insured received any medical advice or treatment from a member of the medical profession, or taken any prescription medicine for:  a. Lung failure, Chronic Obstructive Lung/Pulmonary disease or Emphysema?  b. Organ transplant, liver, kidney or pancreatic failure, cirrhosis of the liver, or hepatitis B or C?  c. Cancer (except basal cell or squamous cell carcinoma), melanoma, Hodgkin's disease, leukemia or malignant growth?  d. Insulin-dependent diabetes at any age or non-insulin dependent diabetes diagnosed under age 40?  e. Dementia, Alzheimer's disease, Parkinson's disease or Multiple Sclerosis?  2. Within the past [10 years], has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for human immunodeficiency virus (AIDS virus) or acquired immunodeficiency syndrome (AIDS)?  3. Within the past [6 months] has the Proposed Insured had any diagnostic tests or procedures for which the results are not yet known, or has the Proposed Insured been recommended to have diagnostic tests and procedures that have not yet been performed?  4. [Within the past [6 months] has the Proposed Insured submitted an application for [Cancer] insurance with any insurance company, which was declined, charged higher-than-standard rates, postponed, cancelled or modified in any way?]  If any of the above questions are answered "Yes", the Proposed Insured is not eligible for coverage.						

[6 1 0 2] [Bar Code] [Application Number] UNDERWRITING INFORMATION Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology Yes No report, echocardiogram, or from imaging, CT or MRI scan? If "Yes", please provide details below: Medical/Diagnostic Diagnosis Treatment Physician Name/ Dates Address/Phone No. Test

_					
PLAN SEI	ECTION				
(	COVERAGE TYPE	FACE AMOUNT (up to \$50,000)	PAYME	ENT METHOD	PREMIUM AMOUNT
[ Choice]	16738 ECA	\$	[□ Bi-weekly EFT] [□ Monthly EFT] [□ Quarterly EFT] [□ Semi-Annual EFT] [□ Annual Bill]	<ul> <li>□ Monthly Credit Card</li> <li>□ Quarterly Credit Card</li> <li>□ Semi-Annual Credit Card</li> <li>□ List Bill</li> <li>□ Other</li> </ul>	\$

# **DECLARATIONS** – This section must be read, signed, and dated by Proposed Insured.

### PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance approves my application, the contract is issued, and the required premium is received by Combined Insurance. In applying for this coverage, I represent and affirm the following:

- 1. The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.
- [2. I received the [Outline of Coverage,] [Privacy Notice][,][and][the MIB Pre-Notice][,][and the Notice Regarding The Fair Credit Reporting Act].]

### CONFIDENTIALITY OF MEDICAL INFORMATION

The medical information disclosed on this Application will not be disclosed to any person without the authorization of the Proposed Insured.

For purposes of this application, "Date of Application" is the date the Licensed Agent/Producer receives and signs the application.

[This application may be completed by electronic or telephonic means. I acknowledge that Combined Insurance or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. If completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. If completed by telephonic means, I acknowledge that I have not myself physically signed the application, but instead I hereby authorize Combined Insurance or its agent to accept my voice signature response. The responses received on this application will be attached and made part of the Policy.]

[Bar Code] [Application Number] [6 1 0 3]

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE. NOTICE: This policy may only be issued if you have minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or you are treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). If you have employer-sponsored coverage, COBRA coverage, insurance purchased from DC Health Link, or other similar insurance, you likely have minimum essential coverage. If your minimum essential coverage is terminated for any reason, you should notify the company immediately. (1) Do you have comprehensive medical coverage including the minimum essential coverage required by the Affordable Care Act (ACA) or are you treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States? Yes ☐ No ☐ If you answered No to question 1, you are not eligible for this policy, in the form of hospital or fixed indemnity insurance. (2) Do you understand most supplemental policies may not pay full benefits if your ACA compliant minimum essential coverage plan is not in force? Yes No No (3) Do you understand that the benefits provided under this policy may be limited? Yes No No WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. By checking this box, I [PROPOSED INSURED NAME] am electronically signing this application for insurance. I represent and affirm that the information I have provided on this application is accurate and complete to the best of my knowledge and belief, and that I have reviewed the Application Declarations, [Outline of Coverage,] and Fraud Warning for my state.]

Signature of Proposed Insured

Signature of Licensed Agent/Producer

City

Agent Code

I, the authorized agent/producer, have on the Date of Application either recorded the information as given to me by the Proposed Insured, or have sent this application to the Proposed Insured and have received the completed and signed application on this date.

State

Date of Application

Combined Insurance Company of America

State: District of Columbia Filing Company:

TOI/Sub-TOI: H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness

Product Name:146500R-DC - Critical IllnessProject Name/Number:16-AH-2013652/16-AH-2013652

# **Supporting Document Schedules**

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Readability Certification.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Vairability Memos
Comments:	
Attachment(s):	Variability Memo - 146500R.pdf Variability Memo - 146700R.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Redline copies
Comments:	
Attachment(s):	146500R-DC DOI Redline 110916.pdf 146700R-DC DOI Redline 110916.pdf
Item Status:	
Status Date:	



## READABILITY CERTIFICATION

Form Numbers: 146500R-DC - Critical Illness Application

146700R-DC - Cancer Only Application

The above captioned form(s) have a Flesch Index Score of <u>SEE BELOW</u> and meet(s) the minimum reading ease requirements.

Form Nos. Flesch Index Score

146500R-DC 50.85 146700R-DC 51.93

Marivic Chiong, Assistant Secretary



# VARIABILITY MEMORANDUM Individual Critical Illness Application Form

Application Form No. 146500R	
Home Office: [Chicago, Illinois]	Bracketed address to alleviate a future filing of
Tiome Office. [Officago, fillifols]	these forms if the company addresses change.
[Language Preference [ $\square$ E ] [ $\square$ S] [ $\square$ F]	these forms if the company addresses change.
Action Requested: [New Policy], [Policy Change],	Bracketed to allow for company decision to
Reinstatement]]	remove if not needed for business operations.
[Landline Phone No.]	Bracketed to accommodate changes in
,	technology and or phone terminology.
[Mobile Phone No.]	Bracketed to accommodate changes in
	technology and or phone terminology.
[Email]	Bracketed to accommodate changes in
	technology and or phone terminology.
[Employer Name	Bracketed to allow for company decision to
[Work Phone Number]	include or exclude the information.
Employer Address (Street) City State ZIP]	
[Beneficiary's Full Name	Bracketed to allow for company decision to
Relationship	include or exclude the information.
Beneficiary's Address (Street) City State ZIP]	
[Billing Address if different than residence (Street) City	Bracketed to allow for company decision to
State ZIP]	include or exclude the information.
[Is the Applicant's household income [\$15,000] per year or	Bracketed to allow the amount to be adjusted
more?]	up or down depending on the economy and
	business decision at the time.
Dannes	\$40,000 \$50,000
Ranges [If "No", the Proposed Insured is not eligible for coverage.]	\$10,000 - \$50,000 Questions may be included or excluded based
[II No , the Proposed Insured is not eligible for coverage.]	on plan offered.
Within the last [12] months, has the Proposed Insured	6 or 12
smoked cigarettes, e-cigarettes, cigars, pipe, or used	0 01 12
nicotine or tobacco products?	
QUALIFICATION QUESTIONS	Bracketed material is dependent on the plan
	design that will be marketed to individuals.
Question #1: [10 years]	5 to 10 years
Question #2: [10 years]	5 to 10 years
Question #3: [10 years]	5 to 10 years
Question #4: [6 months]	6 to 24 months
IF [Within the part IS menthal has the Dranged Incured	Question #5 is breeketed to allow for company
[5. [Within the past [6 months] has the Proposed Insured Submitted an application for [life][or] [critical illness]	Question #5 is bracketed to allow for company decision to include or not include question #5
insurance with any insurance company, which was	dependent on plan design that will be marketed
declined, charged higher-than-standard rates, postponed,	to individuals. Only one version of the
cancelled or modified in any way?	application will be used within the same

	timeframe.
[6 months]	3 months to 2 years
[life] [or]	Bracketed item will either be included or excluded.
[critical illness]	Bracketed item will either be included or excluded.
[UNDERWRITING INFORMATION Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology report, echocardiogram, or from imaging, CT or MRI scan? Yes No [If "Yes", please provide details below: Medical/Diagnostic Test Diagnosis Treatment Dates Physician Name/ Address/Phone No.]]	Bracketed to allow for company decision to include or not include underwriting information dependent on plan design that will be marketed to individuals. Only one version of the application (either with or without the bracketed information) will be used within the same timeframe.
COVERAGE TYPE  [□ Choice] [XXXXX][XXX]  [□ Preferred] [XXXXX][XXX]	Bracketed to allow for company decision to remove or add Plans if not needed for business operations.
Payment Method  [ □ Bi-weekly EFT]  [ □ Monthly EFT]  [ □ Quarterly EFT]  [ □ Semi-Annual EFT]  [ □ Annual Bill]  [ □ Monthly Credit Card]  [ □ Quarterly Credit Card]  [ □ Semi-Annual Credit Card]  [ □ Semi-Annual Credit Card]  [ □ Other]	Bracketed to allow for the removal of one or more modal options.
PLEASE READ CAREFULLY  [2. I received the [Outline of Coverage,] [Privacy Notice][,][and][the MIB Pre-Notice][,][and the Notice Regarding The Fair Credit Reporting Act].]	Bracketed information will either be included or excluded.
[This application may be completed by electronic or telephonic means. I acknowledge that Combined Insurance or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. If completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. If completed by telephonic means, I acknowledge that I have not myself physically signed the application, but instead I hereby authorize Combined Insurance or its agent to accept my voice signature response. The responses received on this application will be attached and made part of the Policy.]	Bracketed for the removal of this statement when the application is not taken by electronic or telephonic means.

[ □ By checking this box, I [PROPOSED INSURED NAME] am electronically signing this application for insurance. I represent and affirm that the information I have provided on this application is accurate and complete to the best of my knowledge and belief, and that I have reviewed the Application Declarations, [Outline of Coverage,] and Fraud Warning for my state.]	Bracketed for the removal of this statement when the application is not taken by electronic means.
Agent Authorization Section	Bracketed to allow for removal of this section when application is taken electronically via the Internet or by Direct Response.



# VARIABILITY MEMORANDUM Individual Cancer Only Application Form

Application Form No. 146700R	
Home Office: [Chicago, Illinois]	Bracketed address to alleviate a future filing of
	these forms if the company addresses change.
[Language Preference [ $\square$ E ] [ $\square$ S ] [ $\square$ F]	
Action Requested: [New Policy], [Policy Change,]	Bracketed to allow for company decision to
[Reinstatement]]	remove if not needed for business operations.
[Landline Phone No.]	Bracketed to accommodate changes in
	technology and or phone terminology.
[Mobile Phone No.]	Bracketed to accommodate changes in
	technology and or phone terminology.
[Email]	Bracketed to accommodate changes in
	technology and or phone terminology.
[Employer Name	Bracketed to allow for company decision to
[Work Phone Number]	include or exclude the information.
Employer Address (Street) City State ZIP]	
[Beneficiary's Full Name	Bracketed to allow for company decision to
Relationship	include or exclude the information.
Beneficiary's Address (Street) City State ZIP]	
[Billing Address if different than residence (Street) City	Bracketed to allow for company decision to
State ZIP]	include or exclude the information.
[Is the Applicant's household income [\$15,000] per year or	Bracketed to allow the amount to be adjusted
more?]	up or down depending on the economy and
	business decision at the time.
Danses	\$40,000 \$50,000
Ranges [If "No", the Proposed Insured is not eligible for coverage.]	\$10,000 - \$50,000 Questions may be included or excluded based
[ii No , the Proposed insured is not eligible for coverage.]	on plan offered.
In the last [12] months, has the Proposed Insured smoked	6 or 12
cigarettes, e-cigarettes, cigars, pipe, or used nicotine or	0 01 12
tobacco products?	
QUALIFICATION QUESTIONS	Bracketed material is dependent on the plan
	design that will be marketed to individuals.
	, and the second
Question #1: [10 years]	5 to 10 years
Question #2: [10 years]	5 to 10 years
Question #4: [6 months]	6 to 24 months
[4. [Within the past [6 months] has the Proposed Insured	Question #4 is bracketed to allow for company
Submitted an application for [cancer] insurance with any	decision to include or not include question #4
insurance company, which was declined, charged higher-	dependent on plan design that will be marketed
than-standard rates, postponed, cancelled or modified in	to individuals. Only one version of the
any way?]	application will be used within the same timeframe.
	umename.
1	

[6 months]	3 months to 2 years
[cancer]	Bracketed item will either be included or excluded.
[UNDERWRITING INFORMATION] Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology report, echocardiogram, or from imaging, CT or MRI scan? Yes No	Bracketed to allow for company decision to include or not include underwriting information dependent on plan design that will be marketed to individuals. Only one version of the application (either with or without the bracketed information) will be used within the same timeframe.
[If "Yes", please provide details below: Medical/Diagnostic Test Diagnosis Treatment Dates Physician Name/ Address/Phone No.]]	
COVERAGE TYPE [□ Choice]	Bracketed to allow for company decision to remove or add Plans if not needed for business operations.
Payment Method  [	Bracketed to allow for the removal of one or more modal options.
PLEASE READ CAREFULLY  [2. I received the [Outline of Coverage,] [Privacy Notice][,][and][the MIB Pre-Notice][,][and the Notice Regarding The Fair Credit Reporting Act].]	Bracketed information will either be included or excluded.
[This application may be completed by electronic or telephonic means. I acknowledge that Combined Insurance or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. If completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. If completed by telephonic means, I acknowledge that I have not myself physically signed the application, but instead I hereby authorize Combined Insurance or its agent to accept my voice signature response. The responses received on this application will be attached and made part of the Policy.]	Bracketed for the removal of this statement when the application is not taken by electronic or telephonic means.
[ □ By checking this box, I [PROPOSED INSURED NAME] am electronically signing this application for insurance. I represent and affirm that the information I have provided on this application is accurate and complete to the best of my knowledge and belief, and that I have reviewed the Application Declarations, [Outline of Coverage,] and Fraud Warning for my state.]	Bracketed for the removal of this statement when the application is not taken by electronic means.

Agent Authorization Section	Bracketed to allow for removal of this section
	when application is taken electronically via the
	Internet or by Direct Response.

# COMBINED INSURANCE COMPANY OF AMERICA

**Application for Critical Illness Coverage** 

Home Office: [Chicago, Illinois]
[LANGUAGE PREFERENCE [□ E] [□ S] [□ F]]

I am applying for this coverage based on the following information:			(Home Office U	se)	
[ACTION REQUESTED:	[□ New Policy] [	☐ Policy Chang	e] [□R	Reinstatement]]	
Proposed Insured's Name (I	☐ Male ☐ Femal	e	Birthdate: MM/DD/YYYY	Age	
Proposed Insured's Home A	ddress (Street)	City		State	Zip
[Landline Phone Number]	[Mobile Phone Number]	[Email]		1	
Employer Name	1	[Work Ph	one Number]		
Employer Address (Street)	c) City			State	Zip
Beneficiary's Full Name			Relationship		
Beneficiary's Address (Stree	et)	City		State	Zip
Billing Address if different than residence (Street)  City				State	Zip
Will this policy replace any ex	isting policies for the Proposed	Insured?	□ Yes □ N	0	
	nold income [\$15,000] per year or med is not eligible for coverage.		□ Yes □ No]		
In the past [12 months], has the P	roposed Insured smoked cigarettes	s, □ Yes □ No		Height	Weight
C-CICALEUES, CICALS, DIDE OF USECT	いしいいた い いいはいい いいいはいいきく	L 169 L 140			100

[Bar Code] [Application Number] [5 9 0 2]

QUALIFICATION QU I represent that the answers 1. Within the past [10 years],	to the below que has the Proposed	Insured receive					V	s No
profession, or taken any prescription medicine for: <ul><li>a. Heart failure, angina, stroke, transient ischemic attack, heart attack, chronic atrial fibrillation, coronary artery disease that</li><li>required angioplasty or stent placement, heart valve repair or replacement?</li></ul>								.S 140
b. Lung failure, Chronic Obstructive Lung/Pulmonary disease or Emphysema?								
c. Organ transplant, liver, kidney or pancreatic failure, cirrhosis of the liver, or hepatitis B or C?								
<ul> <li>d. Cancer (except basal cell or squamous cell carcinoma), melanoma, Hodgkin's disease, leukemia or malignant growth?</li> <li>e. Insulin-dependent diabetes at any age or non-insulin dependent diabetes diagnosed under age 40?</li> </ul>								
f. Bipolar disorder, schiz	, ,			•	rage 40?			
g. Dementia, Alzheimer's			-					
2. Within the past [10 years],					ical profession or tested positiv	ve for		_
human immunodeficiency v	•		-	•				
3. Within the past [10 years],						nol or		
illegal drugs, been on parol								
4. Within the past [6 months]							_	
					have not yet been performe			$\Box$
5. [Within the past [6 months]						ny insurar		
company, which was declin	lea, chargea night	er-man-standar	a rates, pos	aponea, cancelled of mo	odilied in any way?]			را
If any of the above ques	tions are answ	ered "Yes", t	he Propos	sed Insured is not eli	gible for coverage.			
Within the past 24 months, medical or diagnostic tests report, echocardiogram, or	has the proposition	not limited to	, laborato				Υe	s No
If "Yes", please provide de	etails below:							_
Medical/Diagnostic Test	Diagno	osis		Treatment	Dates		sician Nar ess/Phone	
<del>-</del>								
PLAN SELECTION								
COVERAGE TYP	PE	FACE AM (up to \$50					PREM AMOU	
[□ Choice] [XXXXX] [XX [□ Preferred] [XXXXX] [XX	-	\$	[□ Bi-weekly EFT] [□ Monthly Credit Card] [□ Monthly EFT] [□ Quarterly Credit Card] [□ Quarterly EFT] [□ Semi-Annual Credit Card] [□ Semi-Annual EFT] [□ List Bill] [□ Annual Bill] [□ Other]			\$		

[Bar Code] [Application Number] [5 9 0 3]

### DECLARATIONS – This section must be read, signed, and dated by Proposed Insured.

### PLEASE READ CAREFULLY

It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Combined Insurance approves my application, the contract is issued, and the required premium is received by Combined Insurance. In applying for this coverage, I represent and affirm the following:

- 1. The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.
- [2. I received the [Outline of Coverage,] [Privacy Notice][,][and][the MIB Pre-Notice][,][and the Notice Regarding The Fair Credit Reporting Act].]

#### CONFIDENTIALITY OF MEDICAL INFORMATION

The medical information disclosed on this Application will not be disclosed to any person without the authorization of the Proposed Insured.

For purposes of this application, "Date of Application" is the date the Licensed Agent/Producer receives and signs the application.

[This application may be completed by electronic or telephonic means. I acknowledge that Combined Insurance or its Agent has verified my identity for this purpose in accordance with any applicable law or regulation. If completed by electronic means, I agree to provide my consent and authorization to complete an electronic transaction to apply for coverage, and that this authorization shall constitute an electronic signature. If completed by telephonic means, I acknowledge that I have not myself physically signed the application, but instead I hereby authorize Combined Insurance or its agent to accept my voice signature response. The responses received on this application will be attached and made part of the Policy.]

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

If coverage applied for includes Sickness Rider, please complete the attestation below. (If the Proposed Insured checks "No", the Sickness Rider will not be issued.).

**NOTICE:** This policy may only be issued if you have minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or you are treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). If you have employer-sponsored coverage, COBRA coverage, insurance purchased from DC Health Link, or other similar insurance, you likely have minimum essential coverage. If your minimum essential coverage is terminated for any reason, you should notify the company immediately.

(A) D	
(1) Do you have comprehensive medical coverage including the minimum essential coverage required by	
the Affordable Care Act (ACA) or are you treated as having minimum essential coverage due to your status	
as a bona fide resident of any possession of the United States?	☐ Yes ☐ No
If you answered No to question 1, you are not eligible for this policy, in the form of hospital or fixed indemnity ins	urance.
(2) Do you understand most supplemental policies may not pay full benefits if your ACA compliant	
minimum essential coverage plan is not in force?	☐ Yes ☐ No
(3) Do you understand that the benefits provided under this policy may be limited?	☐ Yes ☐ No

WARNING: It is a crime to provide false or misl or any other person. Penalties include imprisor false information materially related to a claim v	nment and/or fines. In a	ddition, an insurer may	
Dy checking this box, I [PROPOSE insurance. I represent and affirm that the inform my knowledge and belief, and that I have reviews state.]	ation I have provided on	this application is accura	te and complete to the best of
XSignature of Proposed Insured	City	State	Date
I, the authorized agent/producer, have on the Date Insured, or have sent this application to the Propos			
XSignature of Licensed Agent/Producer	Agent Code	Date	e of Application

[6 1 0 1] [Application Number]

# COMBINED INSURANCE COMPANY OF AMERICA

COMBINED INSURANCE COMPANY OF AMERICA Application for Cancer Only Coverage				Home Office: [Chic [LANGUAGE PREFEREN	cago, Illinois] NCE [□ E] [□ S] [□ F]]	
	ge based on the following infor	mation:	(Home Office Us	se)		
[ACTION REQUESTED:	<b>[</b> □ New Policy ] [□	Policy Change	e] [ $\square$	☐ Reinstateme	nt]]	
Proposed Insured's Name (F	ïrst MI Last)	☐ Male ☐ Femal	e	Birthdate:	MM/DD/YYYY	Age
Proposed Insured's Home Ad	ddress (Street)	City			State	Zip
[Landline Phone Number]	[Mobile Phone Number]	[Email]				
Employer Name		[Work Pho	one Number]			
Employer Address (Street)		City			State	Zip
Beneficiary's Full Name					Relationship	
Beneficiary's Address (Street	t)	City			State	Zip
Billing Address if different than residence (Street)  City  State			State	Zip		
Will this policy replace any exis	sting policies for the Proposed Ins	sured?	□ Yes □ No	0		
	old income [\$15,000] per year or mor dis not eligible for coverage.]	·e?	□ Yes □ No]			
· -	roposed Insured smoked cigarettes,				Height	Weight
e-cigarettes, cigars, pipe or used ni	cotine or tobacco products?	l Yes □ No	ı		FTIN.	LBS.
1. Within the past [10 years], ha profession, or taken any pres a. Lung failure, Chronic Ol b. Organ transplant, liver, c. Cancer (except basal ce d. Insulin-dependent diabe e. Dementia, Alzheimer's c. Within the past [10 years], ha human immunodeficiency viri.  3. Within the past [6 months] ha or has the Proposed Insured 4. [Within the past [6 months] ha company, which was declined.]	o the below questions are accurate as the Proposed Insured received any	r medical advicer medical advicer Emphysema? of the liver, or anoma, Hodgkin ent diabetes diaple Sclerosis? sed by a membericiency syndromostic tests or tic tests and pran application for postponed, co	he or treatment from hepatitis B or C? hepatitis B or C? n's disease, leukem agnosed under age her of the medical prome (AIDS)? procedures for which rocedures that have for [Cancer] insurance ancelled or modifier	nia or malignante 40?  profession or tech the results are not yet been proce with any intended in any way?	the medical  at growth?  ested positive for  are not yet known, performed? asurance  2]	Yes No

[6 1 0 2] [Bar Code] [Application Number] UNDERWRITING INFORMATION Within the past 24 months, has the proposed insured been diagnosed with a medical condition as a result of medical or diagnostic tests, including but not limited to, laboratory test, x-ray, ultrasound, biopsy, pathology Yes No report, echocardiogram, or from imaging, CT or MRI scan? If "Yes", please provide details below: Medical/Diagnostic Diagnosis Treatment Physician Name/ Dates Address/Phone No. Test

_					
PLAN SEI	ECTION				
(	COVERAGE TYPE	FACE AMOUNT (up to \$50,000)	PAYME	ENT METHOD	PREMIUM AMOUNT
[ Choice]	16738 ECA	\$	[□ Bi-weekly EFT] [□ Monthly EFT] [□ Quarterly EFT] [□ Semi-Annual EFT] [□ Annual Bill]	<ul> <li>□ Monthly Credit Card</li> <li>□ Quarterly Credit Card</li> <li>□ Semi-Annual Credit Card</li> <li>□ List Bill</li> <li>□ Other</li> </ul>	\$

# **DECLARATIONS** – This section must be read, signed, and dated by Proposed Insured.

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[Bar Code] [Application Number] [6 1 0 3]

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CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.	"
If coverage applied for includes Sickness Rider, please complete the attestation below. (If the Proposed Insured checks "No Rider will not be issued.).  NOTICE: This policy may only be issued if you have minimum essential coverage within the meaning of section Internal Revenue Code, or you are treated as having minimum essential coverage due to your status as a bona possession of the United States pursuant to Code section 5000A(f)(4)(B). If you have employer-sponsored coverage, insurance purchased from DC Health Link, or other similar insurance, you likely have minimum essential coverage is terminated for any reason, you should notify the company immediately.	5000A(f) of the ide resident of any age, COBRA
(1) Do you have comprehensive medical coverage including the minimum essential coverage required by the Affordable Care Act (ACA) or are you treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States?  If you answered No to question 1, you are not eligible for this policy, in the form of hospital or fixed indemnity insurance.	Yes 🗌 No 🗌
<ul><li>(2) Do you understand most supplemental policies may not pay full benefits if your ACA compliant minimum essential coverage plan is not in force?</li><li>(3) Do you understand that the benefits provided under this policy may be limited?</li></ul>	Yes  No  Yes No  No
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrau or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurfalse information materially related to a claim was provided by the applicant.	
[ By checking this box, I [PROPOSED INSURED NAME] am electronically signing this insurance. I represent and affirm that the information I have provided on this application is accurate and commy knowledge and belief, and that I have reviewed the Application Declarations, [Outline of Coverage,] and Frastate.]	plete to the best of
X Signature of Proposed Insured City State	Date
I, the authorized agent/producer, have on the Date of Application either recorded the information as given to me Insured, or have sent this application to the Proposed Insured and have received the completed and signed application.	
Signature of Licensed Agent/Producer Agent Code Date of Applica	tion